IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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CORRECTED COPY

April 5, 2012

Susan Broetje, Administrator
Southwest Idaho Treatment Center
1660 Eleventh Avenue North
Nampa, Idaho 83687

RE: Southwest Idaho Treatment Center, Provider #13G001

Dear Ms. Broetje:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Southwest Idaho Treatment Center, on March 20, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

NOTE: Please replace the copy of this letter that was mailed to your office on March 29, 2012, with this copy. A revision has been made to the tag(s) cited on Building 10. Enclosed, you will find the revised Form CMS-2567 for Building 10. Please replace the existing report for Building 10 with this copy. After you have completed your Plan of Correction, return the original to this office by **April 11, 2012**, and keep a copy for your records.

Thank you for the courtesies extended to me during my visit. If you have any questions, please call our office at (208) 334-6626.

Sincerely,

MARK P. GRIMES
Supervisor
Fire Life Safety & Construction Program

MPG/lj

Enclosure

)EPARTMENT OF HEALTH AND HUMAN SERVICES
:ENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 01 B. WING _____	03/20/2012

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
:OUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The "Redwood" building was originally constructed in 1967 and is a single story structure with mechanical room in the basement. The building's original construction classification is protected non-combustible Type V (111). The building is now fully sprinklered as of 2010. The building is protected throughout by a complete, supervised fire alarm/smoke detection system with off-site monitoring. There is a total of two (2) exits to grade from the central core plus each of the four "pods" containing resident sleeping has a door directly to grade and a door to the central core. Emergency power and lighting is provided by an on-site, fuel-fired generator. The Redwood building was vacated in July 2011 and is no longer utilized by facility clients. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
SBloetje	Administrative Director	4/10/12

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 01 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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M 000	16.03.11 Initial Comments The "Redwood" building was originally constructed in 1967 and is a single story structure with mechanical room in the basement. The building's original construction classification is protected non-combustible Type V (111). The building is now fully sprinklered as of 2010. The building is protected throughout by a complete, supervised fire alarm/smoke detection system with off-site monitoring. There is a total of two (2) exits to grade from the central core plus each of the four "pods" containing resident sleeping has a door directly to grade and a door to the central core. Emergency power and lighting is provided by an on-site, fuel-fired generator. The Redwood building was vacated in July 2011 and is no longer utilized by facility clients. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000	RECEIVED APR 17 2012 FACILITY STANDARDS refer to cms 2567	

aho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
DBuckle	ADMINISTRATIVE DIRECTOR	4/10/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	13G001	A. BUILDING 02 B. WING _____	03/20/2012

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K 000	INITIAL COMMENTS The medical building is a single story structure of protected wood frame construction. The original building was constructed in 1963 and the "E" wing addition in 1977. The building is protected throughout by a complete automatic fire extinguishing system and an upgraded fire alarm/smoke detection system. Multiple exits to grade serve the building , plus there are direct exits to grade from several "suits" within the building. Emergency power is supplied by two on-site, fuel fired, automatic generators; one serving the original building and the other serves the 1977 addition. Wings "B" and "C", essentially unoccupied since Fall 2010, are separated from the remainder of the building by two hour rated wall assemblies. The entire Medical building was vacated in May 2011 and is no longer utilized by facility clients. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATIVE DIRECTOR	4/10/12

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

Bureau of Facility Standards

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	13G001	A. BUILDING 02 - MEDICAL BLDG B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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Bureau of Facility Standards

DBroetje ADMINISTRATIVE DIRECTOR 4/10/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	13G001	A. BUILDING 03 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 000	INITIAL COMMENTS The "Aspen" building is a single story structure, with a mechanical loft, that was completed/occupied in December of 2002. The building's construction classification is Type V(111) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. Emergency power is supplied by an on-site, fuel fired, automatic generator as well as some battery pack emergency lighting. The building consists of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing resident sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls. This building has 20 ICF/ID beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with 42 CFR 483.70. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000	RECEIVED APR 17 2012 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
SBrocty	ADMINISTRATIVE DIRECTOR	4/10/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	Continued From page 1	K 000		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility did not ensure that the emergency lights were being tested for 30 seconds a month. Failure to test the emergency lights can result in nonoperational units not being discovered and repaired. The facility had a census of fifteen clients on the day of survey. This deficiency affected all clients, staff and visitors present on the day of the survey. Findings include: During record review on March 20, 2012 at 9:57 AM, it was revealed that emergency light testing records were not available for the month of May 2011. When questioned about emergency light testing records the Maintenance Supervisor stated that he was unsure why the test was not completed and documented. Actual NFPA Standard: NFPA 101® Life Safety Code ® 2000 Edition Chapter 19 EXISTING HEALTH CARE OCCUPANCIES 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.	K 046	**TAG # K046 (MM309) – Aspen - page 2 of 8** During record review on March 20, 2012 at 9:57 am, it was revealed that emergency light testing records were not available for the month of May 2011. When questioned about emergency light testing records the Maintenance Supervisor stated that he was unsure why the test was not completed and documented. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. Emergency light testing will be completed by the 20th of each month and documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor* C. Date of action for the identified problem. *New system will be in place by May 30, 2012* 5/30/12	

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K 046	Continued From page 2 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046		
K 052	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This Standard is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure that fire alarm was being maintained in accordance with NFPA 72. Failure to conduct annual inspections and repairing nonoperational equipment could result in the fire alarm system not functioning as designed. The facility had a census of fifteen clients on the day of survey.	K 052		

)EPARTMENT OF HEALTH AND HUMAN SERVICES
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	13G001	A. BUILDING 03 B. WING _____	03/20/2012

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 052	Continued From page 3 These deficiencies affected all clients, staff, and visitors present on the day of the survey. Findings include: 1. During record review on March 20, 2012 at 9:40 AM, it was revealed that the last documented annual fire alarm inspection report was dated January 4, 2011. When questioned about the annual inspection the Maintenance Supervisor stated that he was aware that the inspection was overdue. 2. During record review on March 20, 2012 at 9:40 AM, it was revealed that the last documented annual fire alarm inspection report dated January 4, 2011, documented that the smoke detectors in rooms #155, 187 and 196 do not operate correctly. When questioned about the smoke detectors the Maintenance Supervisor stated that he was unsure if they were repaired. Actual NFPA Standard: Chapter 19 Existing Healthcare Occupancies 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. 7-3 Inspection and Testing Frequency. 7-3.1* Visual Inspection. Visual inspection shall be performed in accordance with the schedules in Section 7-3 or more often if required by the authority having jurisdiction. The visual inspection shall be made	K 052	**TAG # K052 (MM309) (#1) – Aspen - page 4 of 8** During record review on March 20, 2012 at 9:40 AM, it was revealed that the last documented annual fire alarm inspection report was dated January 4, 2011. When questioned about the annual inspection, the Maintenance Supervisor stated that he was aware that the inspection was overdue. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. Annual fire alarm inspections will be scheduled by the 1st of the month due. Documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* *The 2012 fire alarm inspection was initiated on 3/20/12 and we received the report of findings on 4/6/12.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. Maintenance and Operations Supervisor C. Date of action for the identified problem. *New system will be in place by May 30, 2012* 5/30/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 052	Continued From page 4 to ensure that there are no changes that affect equipment performance. 7-1.1.2 System defects and malfunctions shall be corrected. If a defect or malfunction is not corrected at the conclusion of system inspection, testing, or maintenance, the system owner or the owner ' s designated representative shall be informed of the impairment in writing within 24 hours.	K 052	**Tag #K052 (MM309) (#2) – Aspen - page 4 of 8** During record review on March 20, 2012 at 9:40 AM, it was revealed that the last documented annual fire alarm inspection report dated January 4, 2011, documented that the smoke detectors in rooms #155, 187, and 196 do not operate correctly. When questioned about the smoke detectors, the Maintenance Supervisor stated that he was unsure if they were repaired. A. Correction action for the identified problem. *The Maintenance and Operations Supervisor will ensure and document in a report to the SWITC Administrative Director that each issue identified in the fire alarm inspection report is corrected within 30 days of receiving the annual fire alarm inspection report.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor* C. Date of action for the identified problem. *First report from the Maintenance and Operations Supervisor will be completed by 4/30/12 for the 2012 annual fire alarm inspection.* 4/30/12	
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility did not ensure that the emergency generator monthly load tests were being conducted in accordance with NFPA 110. Conducting monthly load tests help to ensure system reliability. The facility had a census of fifteen clients on the day of survey. This deficiency affected all clients, staff and visitors present on the day of the survey. Findings include:	K 144		

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K 144	Continued From page 5 During record review on March 20, 2012 at 10:06 AM, the facility was unable to provide a documented thirty minute load test for the generator during the month of August 2011. When questioned about the load test the Maintenance Supervisor stated that he did know why the test was not conducted and documented. Actual NFPA Standard: NFPA 110 Standard for Emergency and Standby Power Systems 1999 Edition 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.	K 144	**TAG # K144 (MM309) – Aspen - page 6 of 8** During the review on March 20, 2012 at 10:06 AM, the facility was unable to provide a documented thirty minute load test for the generator during the month of August 2011. When questioned about the load test the Maintenance Supervisor stated that he did know why the test was not conducted and documented. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. The thirty minute load test will be completed by the 20th of each month and documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor* C. Date of action for the identified problem. *New system will be in place by May 30, 2012*	5/30/12
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147	Continued From page 6 This Standard is not met as evidenced by: Based on observation and interview the facility did not ensure that electrical wiring and equipment usage was in accordance with NFPA 70 and NFPA 99. Utilizing multiple outlet adapters can lead to overloaded wiring and start a fire. The facility had a census of fifteen clients on the day of survey. This deficiency affected fifteen clients and two staff members in one of three smoke compartments. Findings include: During the tour of the facility on March 19, 2012 at 10:35 AM, observation of room # 165 revealed a multiple adapter in use. When questioned about the adapter, the Maintenance Supervisor stated that he was unaware of the adapter's presence in that room. Actual NFPA Standard: NFPA 99 Standard for Health Care Facilities 1999 Edition 3-3.2.1.2 All Patient Care Areas. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. NFPA 70 National Electrical Code 1999 Edition 110-3. Examination, Identification, Installation, and Use of Equipment (a) Examination. In judging equipment, considerations such as the following shall be evaluated: 1. Suitability for installation and use in conformity	K 147	**TAG #K147 (MM309) – Aspen - page 7 of 8** During the tour of the facility on March 19, 2012 at 10:35 AM, observation of Room # 165 revealed a multiple adapter in use. When questioned about the adapter, the Maintenance Supervisor stated he was unaware of the adapter's presence in the room. A. Correction action for the identified problem. *A monthly inspection checklist to review for Fire Life Safety requirements will be developed. The maintenance personnel assigned to the buildings will complete monthly inspections of the buildings and document any observed concerns. These concerns will be shared with the applicable building manager for correction. The completed checklist will be submitted to the Maintenance and Operations Supervisor for review and assurance that all needed corrections have been completed.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor.* C. Date of action for the identified problem. *Corrected as of 4/6/12* 4/6/12	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 03 B. WING _____	03/20/2012

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 147	Continued From page 7 with the provisions of this Code FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling. 2. Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided 3. Wire-bending and connection space 4. Electrical insulation 5. Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service 6. Arcing effects 7. Classification by type, size, voltage, current capacity, and specific use 8. Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (b) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.	K 147		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 000	16.03.11 Initial Comments The "Aspen" building is a single story structure, with a mechanical loft, that was completed/occupied in December of 2002. The building's construction classification is Type V(111) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. Emergency power is supplied by an on-site, fuel fired, automatic generator as well as some battery pack emergency lighting. The building consists of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing resident sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls. This building has 20 ICF/ID beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000	RECEIVED APR 17 2012 FACILITY STANDARDS CMS refer to 2567	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
S Bruetz	ADMINISTRATIVE DIRECTOR	4/10/12

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 000	Continued From Page 1	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities. This Rule is not met as evidenced by: Refer to the Federal K Tags on the CMS 2567; 1. K046 Emergency light testing. 2. K052 Fire alarm maintenance. 3. K144 Emergency generator load tests. 4. K147 Electrical equipment.	MM309	refer to CMS 2567	

)EPARTMENT OF HEALTH AND HUMAN SERVICES
:ENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	INITIAL COMMENTS The "Birch" building is a single story structure, with a mechanical loft, that was completed/occupied in December 2002. The building's construction classification is Type V(III) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and fire/ smoke detection system. Emergency power is supplied by an on site, fuel fired, automatic generator as well as battery pack emergency lighting. The building consists of of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls. The building is licensed for 20 ICF/ID beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with 42 CFR 483.70. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
SBroetje	ADMINISTRATIVE DIRECTOR	4/10/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1	K 000		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility did not ensure that the emergency lights were being tested for 30 seconds a month. Failure to test the emergency lights can result in nonoperational units not being discovered and repaired. The facility had a census of fifteen clients on the day of survey. This deficiency affected all clients, staff and visitors present on the day of the survey. Findings include: During record review on March 20, 2012 at 9:59 AM, it was revealed that emergency light testing records were not available for the month of May 2011. When questioned about emergency light testing records the Maintenance Supervisor stated that he was unsure why the test was not completed and documented. Actual NFPA Standard: NFPA 101® Life Safety Code ® 2000 Edition Chapter 19 EXISTING HEALTH CARE OCCUPANCIES 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.	K 046	**TAG # K046 (MM309) – Birch - page 2 of 10** During record review on March 20, 2012 at 9:59 am, it was revealed that emergency light testing records were not available for the month of May 2011. When questioned about emergency light testing records the Maintenance Supervisor stated that he was unsure why the test was not completed and documented. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. Emergency light testing will be completed by the 20th of each month and documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor* C. Date of action for the identified problem. *New system will be in place by May 30, 2012.* 5/30/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 046	Continued From page 2 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046	**TAG # K052 (#1) (MM309) – Birch - page 4 of 10** During record review on March 20, 2012 at 9:42 AM, it was revealed that the last documented annual fire alarm inspection report was dated January 10, 2011. When questioned about the annual inspection the Maintenance Supervisor stated that he was aware that the inspection was overdue. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. Annual fire alarm inspections will be scheduled by the 1st of the month due. Documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* *The 2012 fire alarm inspection was initiated on 3/20/12 and we received the report of findings on 4/6/12.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. Maintenance and Operations Supervisor C. Date of action for the identified problem. *New system will be in place by May 30, 2012* 5/30/12	
K 052	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This Standard is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure that fire alarm was being maintained in accordance with NFPA 72. Failure to conduct annual inspections and repairing nonoperational equipment could result in the fire alarm system not functioning as designed. The facility had a census of fifteen clients on the day of survey.	K 052		

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K 052	Continued From page 3 These deficiencies affected all clients, staff, and visitors present on the day of the survey. Findings include: 1. During record review on March 20, 2012 at 9:42 AM, it was revealed that the last documented annual fire alarm inspection report was dated January 5, 2011. When questioned about the annual inspection the Maintenance Supervisor stated that he was aware that the inspection was overdue. 2. During record review on March 20, 2012 at 9:42 AM, it was revealed that the last documented annual fire alarm inspection report dated January 4, 2011, documented that one horn strobe and the post indicator valve tamper switch do not operate correctly. When questioned about the horn strobe and tamper switch the Maintenance Supervisor stated that he was unsure if they were repaired. Actual NFPA Standard: Chapter 19 Existing Healthcare Occupancies 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. 7-3 Inspection and Testing Frequency. 7-3.1* Visual Inspection. Visual inspection shall be performed in accordance with the schedules in Section 7-3 or more often if required by the authority having	K 052	**Tag #052 (#2) (MM309) – Birch - page 4 of 10** During record review on the March 20, 2012 at 9:42 AM, it was revealed that the last documented annual fire alarm inspection report dated January 4, 2011, documented that one horn strobe and the post indicator valve tamper switch do not operate correctly. When questioned about the horn strobe and tamper switch the Maintenance supervisor stated he was unsure if they were repaired. A. Correction action for the identified problem. *The Maintenance and Operations Supervisor will ensure and document in a report to the SWITC Administrative Director that each issue identified in the fire alarm inspection report is corrected within 30 days of receiving the annual fire alarm inspection report.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor* C. Date of action for the identified problem. *First report from the Maintenance and Operations Supervisor will be completed by 4/30/12 for the 2012 annual fire alarm inspection.* 4/30/12	

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K 052	Continued From page 4 jurisdiction. The visual inspection shall be made to ensure that there are no changes that affect equipment performance. 7-1.1.2 System defects and malfunctions shall be corrected. If a defect or malfunction is not corrected at the conclusion of system inspection, testing, or maintenance, the system owner or the owner ' s designated representative shall be informed of the impairment in writing within 24 hours.	K 052		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility did not ensure that the emergency generator monthly load tests were being conducted in accordance with NFPA 110. Conducting monthly load tests help to ensure system reliability. The facility had a census of fifteen clients on the day of survey. This deficiency affected all clients, staff and visitors present on the day of the survey. Findings include:	K 144		

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K 144	Continued From page 5 During record review on March 20, 2012 at 10:06 AM, the facility was unable to provide a documented thirty minute load test for the generator during the month of August 2011. When questioned about the load test the Maintenance Supervisor stated that he did know why the test was not conducted and documented. Actual NFPA Standard: NFPA 110 Standard for Emergency and Standby Power Systems 1999 Edition 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a). Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.	K 144	**TAG # K144 (MM309) – Birch - page of 6 of 10** During the review on March 20, 2012 at 10:06 AM, the facility was unable to provide a documented thirty minute load lest for the generator during the month of August 2011. When questioned about the load test the Maintenance Supervisor stated that he did know why the test was not conducted and documented. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. The thirty minute load test will be completed by the 20th of each month and documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor* C. Date of action for the identified problem. *New system will be in place by May 30, 2012.*	5/30/12
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147	Continued From page 6 This Standard is not met as evidenced by: Based on observation and interview the facility did not ensure that electrical wiring and equipment usage was in accordance with NFPA 70 and NFPA 99. Utilizing relocatable power taps can lead to overloaded wiring and start a fire. The facility had a census of fifteen clients on the day of survey. This deficiency affected all clients, staff and visitors present on the day of the survey. Findings include: During the tour of the facility on March 19, 2012 at 11:05 AM, observation of the common area revealed a relocatable power tap supplying power to another relocatable power tap that was powering a fishtank. When questioned about the power taps the Maintenance Supervisor stated that he was unaware of the relocatable power taps being utilized for the fishtank. Actual NFPA Standard: NFPA 99 Standard for Health Care Facilities 1999 Edition 3-3.2.1.2 All Patient Care Areas. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. NFPA 70 National Electrical Code 1999 Edition 110-3. Examination, Identification, Installation, and Use of Equipment (a) Examination. In judging equipment, considerations such as the following shall be	K 147	**TAG # K147 (MM309) – Birch - page 7 of 10** During the tour of the facility on March 19, 2012 at 11:05 AM, observation of the common area revealed a relocatable power tap supplying power to another relocatable power tap that was powering a fish tank. When questioned about the power taps Maintenance Supervisor stated that he was unaware of the power taps being used for the fish tank. A. Correction action for the identified problem. *A monthly inspection checklist to review for Fire Life Safety requirements will be developed. The maintenance personnel assigned to the buildings will complete monthly inspections of the buildings and document any observed concerns. These concerns will be shared with the applicable building manager for correction. The completed checklist will be submitted to the Maintenance and Operations Supervisor for review and assurance that all needed corrections have been completed.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor.* C. Date of action for the identified problem. *Corrected as of 4/6/12* 4/6/12	

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K 147	Continued From page 7 evaluated: 1. Suitability for installation and use in conformity with the provisions of this Code FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling. 2. Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided 3. Wire-bending and connection space 4. Electrical insulation 5. Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service 6. Arcing effects 7. Classification by type, size, voltage, current capacity, and specific use 8. Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (b) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. UL 1363 RELOCATABLE POWER TAPS (XBYS) Relocatable Power TapsXBYSUSE AND INSTALLATION This category covers relocatable power taps rated 250 V ac or less, 20 A or less. They are intended for indoor use as relocatable multiple outlet extensions of a single branch circuit to supply laboratory equipment, home workshops, home movie lighting controls, musical	K 147		

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OUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 147	Continued From page 8 instrumentation, and to provide outlet receptacles for computers, audio and video equipment, and other equipment. They consist of one attachment plug and a single length of flexible cord terminated in a single enclosure in which one or more receptacles are mounted. They may, in addition, be provided with fuses or other supplementary overcurrent protection, switches, suppression components and/or indicator lights in any combination, or connections for cable, communications, telephone and/or antenna. Relocatable power taps are intended to be directly connected to a permanently installed branch circuit receptacle. Relocatable power taps are not intended to be series connected (daisy chained) to other relocatable power taps or to extension cords. Relocatable power taps are not intended for use at construction sites and similar locations. Relocatable power taps are not intended to be permanently secured to building structures, tables, work benches or similar structures, nor are they intended to be used as a substitute for fixed wiring. The cords of relocatable power taps are not intended to be routed through walls, windows, ceilings, floors or similar openings. Relocatable power taps have not been investigated and are not intended for use with general patient care areas or critical patient care areas of health care facilities as defined in Article 517 of ANSI/NFPA 70, "National Electrical Code."	K 147		
K 211	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft	K 211		

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 04 B. WING _____	03/20/2012

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
:OUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 9 from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This Standard is not met as evidenced by: Based on observation and interview the facility did not ensure that alcohol based hand rub dispensers were not installed over an ignition source. This deficiency could start a fire in the event of container leakage. The facility had a census of fifteen clients on the day of survey. This deficiency affected fifteen clients and two staff members in one of three smoke compartments. Findings include: During the tour of the facility on March 19, 2012 at 11:12 AM, observation of rooms # 190, 194 and 196 revealed alcohol based hand rub dispensers installed above wall mounted lights. When questioned about the dispensers, the Maintenance Supervisor stated that he was unaware of the dispenser installations in those rooms.	K 211	**TAG # K211 (MM309) – Birch - page 10 of 10** During the tour of the facility on March 19, 2012 at 11:12 AM, observation of rooms, #190, 194, and 196 revealed alcohol base hand rub dispensers installed about wall mounted lights. When questioned about the dispensers, the Maintenance supervisor stated he was unaware of the dispensers' installations in those rooms. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. The maintenance personnel assigned to the buildings will complete monthly inspections of the buildings for these types of issues.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor* C. Date of action for the identified problem. *Corrected as of 3/21/12*	3/21/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 04 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments The "Birch" building is a single story structure, with a mechanical loft, that was completed/occupied in December 2002. The building's construction classification is Type V(III) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and fire/ smoke detection system. Emergency power is supplied by an on site, fuel fired, automatic generator as well as battery pack emergency lighting. The building consists of of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls. The building is licensed for 20 ICF/ID beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000	RECEIVED APR 17 2012 FACILITY STANDARDS refer to CMS 2567	

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
SBrooke	ADMINISTRATIVE DIRECTOR	4/10/12

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 000	Continued From Page 1	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities. This Rule is not met as evidenced by: Refer to the Federal K Tags on the CMS 2567; 1. K211 Alcohol based hand rub dispensers. 2. K046 Emergency light testing. 3. K052 Fire alarm maintenance. 4. K144 Emergency generator load tests. 5. K147 Electrical equipment.	MM309	refer to cms 2567	

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	13G001	A. BUILDING 05 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		

The "Pine" building is a single story structure with a mechanical loft, that was completed/occupied in December of 2002. The building's construction classification is Type V(111) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. Emergency power is supplied by an on-site, fuel fired, automatic generator as well as some battery pack emergency lighting. The building consists of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls. This building has 20 ICF/ID beds.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with 42 CFR 483.70.

The Survey was conducted by:

Taylor Barkley
Health Facility Surveyor
Facility Fire Safety and Construction

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
S Buettge	ADMINISTRATIVE DIRECTOR	4/10/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

:TATEMENT OF DEFICIENCIES .ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1	K 000		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility did not ensure that the emergency lights were being tested for 30 seconds a month. Failure to test the emergency lights can result in nonoperational units not being discovered and repaired. The facility had a census of seventeen clients on the day of survey. This deficiency affected all clients, staff and visitors present on the day of the survey. Findings include: During record review on March 20, 2012 at 10:00 AM, it was revealed that emergency light testing records were not available for the month of May 2011. When questioned about emergency light testing records the Maintenance Supervisor stated that he was unsure why the test was not completed and documented. Actual NFPA Standard: NFPA 101® Life Safety Code ® 2000 Edition Chapter 19 EXISTING HEALTH CARE OCCUPANCIES 19.2.9.1 Emergency lighting shall be provided in	K 046	**TAG # K046 (MM309) – Pine page 2 of 6** During record review on March 20, 2012 at 10:00 am, it was revealed that emergency light testing records were not available for the month of May 2011. When questioned about emergency light testing records the Maintenance Supervisor stated that he was unsure why the test was not completed and documented. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. Emergency light testing will be completed by the 20th of each month and documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor* C. Date of action for the identified problem. *New system will be in place by May 30, 2012.* 5/30/12	

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OUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 046	Continued From page 2 accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046		
K 052	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This Standard is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure that fire alarm was being maintained in accordance with NFPA 72. Failure to conduct annual inspections and repairing nonoperational equipment could result in the fire alarm system not functioning as designed. The facility had a	K 052		

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SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 052	Continued From page 3 census of seventeen clients on the day of survey. This deficiency affected all clients, staff, and visitors present on the day of the survey. Findings include: During record review on March 20, 2012 at 9:43 AM, it was revealed that the last documented annual fire alarm inspection report was dated January 10, 2011. When questioned about the annual inspection the Maintenance Supervisor stated that he was aware that the inspection was overdue. Actual NFPA Standard: Chapter 19 Existing Healthcare Occupancies 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. 7-3 Inspection and Testing Frequency. 7-3.1* Visual Inspection. Visual inspection shall be performed in accordance with the schedules in Section 7-3 or more often if required by the authority having jurisdiction. The visual inspection shall be made to ensure that there are no changes that affect equipment performance.	K 052	**TAG # K052 (MM309) – Pine - page 4 of 6** 5/30/12 During record review on March 20, 2012 at 9:43 AM, it was revealed that the last documented annual fire alarm inspection report was dated January 10, 2011. When questioned about the annual inspection the Maintenance Supervisor stated that he was aware that the inspection was overdue. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. Annual fire alarm inspections will be scheduled by the 1st of the month due. Documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* *The 2012 fire alarm inspection was initiated on 3/20/12 and we received the report of findings on 4/6/12.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. Maintenance and Operations Supervisor C. Date of action for the identified problem. *New system will be in place by May 30, 2012*	
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 4 This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility did not ensure that the emergency generator monthly load tests were being conducted in accordance with NFPA 110. Conducting monthly load tests help to ensure system reliability. The facility had a census of seventeen clients on the day of survey. This deficiency affected all clients, staff and visitors present on the day of the survey. Findings include: During record review on March 20, 2012 at 10:06 AM, the facility was unable to provide a documented thirty minute load test for the generator during the month of August 2011. When questioned about the load test the Maintenance Supervisor stated that he did know why the test was not conducted and documented. Actual NFPA Standard: NFPA 110 Standard for Emergency and Standby Power Systems 1999 Edition 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.	K 144	**TAG # K144 (MM309) – Pine - page 5 of 6** During the review on March 20, 2012 at 10:06 AM, the facility was unable to provide a documented thirty minute load lest for the generator during the month of August 2011. When questioned about the load test the Maintenance Supervisor stated that he did know why the test was not conducted and documented. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. The thirty minute load test will be completed by the 20th of each month and documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor* C. Date of action for the identified problem. *New system will be in place by May 30, 2012* 5/30/12	

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K 144	Continued From page 5 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.	K 144		

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M 000	16.03.11 Initial Comments The "Pine" building is a single story structure with a mechanical loft, that was completed/occupied in December of 2002. The building's construction classification is Type V(111) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. Emergency power is supplied by an on-site, fuel fired, automatic generator as well as some battery pack emergency lighting. The building consists of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls. This building has 20 ICF/ID beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000	RECEIVED APR 17 2012 FACILITY STANDARDS refer to CMS 2567	

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR DIRECTOR	4/10/12

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M 000	Continued From Page 1	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities. This Rule is not met as evidenced by: Refer to the Federal K Tags on the CMS 2567; 1. K046 Emergency light testing. 2. K052 Annual fire alarm inspection. 3. K144 Emergency generator monthly load test.	MM309	refer to cms 2567	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	13G001	A. BUILDING 06 B. WING _____	03/20/2012

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K 000	INITIAL COMMENTS The Mini Gym #1 is the multi-purpose building constructed in November 2002 as an unattached Type V(III) building. The structure is used for sports activities and is principally equipped with a basketball floor and hoops. There is a fire alarm system installed in the building and exiting classification is remote capability. Battery pack emergency lighting is provided. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, and in accordance with 42 CFR 483.70. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by:	K 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 130	Continued From page 1 Based on record review and interview it was determined that the facility did not ensure that the emergency lights were being tested for 30 seconds a month. Failure to test the emergency lights can result in nonoperational units not being discovered and repaired. The facility had a census of forty seven clients on the day of survey. This deficiency affected all clients, staff and visitors present on the day of the survey. Findings include: During record review on March 20, 2012 at 10:02 AM, it was revealed that emergency light testing records were not available for the month of May 2011. When questioned about emergency light testing records the Maintenance Supervisor stated that he was unsure why the test was not completed and documented. Actual NFPA Standard: 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 130	**TAG # K130 (MM309) – Aspen Mini Gym #1 - page 2 of 2** During record review on March 20, 2012 at 10:02 AM, it was revealed that the emergency light testing records were not available for the month of May 2011. When questioned about the emergency light testing records the Maintenance Supervisor stated he was unsure why the test was not completed and documented. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. Emergency light testing will be completed by the 20th of each month and documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor* C. Date of action for the identified problem. *New system will be in place by May 30, 2012.* 5/30/12	

ureau of Facility Standards

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 06 B. WING _____	03/20/2012

IAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments The Mini Gym #1 is the multi-purpose building constructed in November 2002 as an unattached Type V(III) building. The structure is used for sports activities and is principally equipped with a basketball floor and hoops. There is a fire alarm system installed in the building and exiting classification is remote capability. Battery pack emergency lighting is provided. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000	RECEIVED APR 17 2012 FACILITY STANDARDS refer to Cms 2567	
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must	MM309		

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
SBroetje	ADMINISTRATIVE DIRECTOR	4/10/12

ureau of Facility Standards

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 06 B. WING _____	03/20/2012

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM309	Continued From Page 1 meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities. This Rule is not met as evidenced by: Refer to the Federal K Tags on the CMS 2567; 1. K130 Emergency light testing.	MM309	refer to CMS 2567	

)EPARTMENT OF HEALTH AND HUMAN SERVICES
:ENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 07 B. WING _____	03/20/2012

IAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The Mini Gym #2 is the multi-purpose building constructed in November 2002 as an unattached Type V(III) building. The structure is used for sports activities and is principally equipped with a basketball floor and hoops. There is a fire alarm system installed in the building and exiting classification is remote capability. Battery pack emergency lighting is provided. The Mini Gym #2 building was vacated in June 2011 and is no longer utilized by facility clients. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000		

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APR 17 2012
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

S Blue ADMINISTRATIVE DIRECTOR 4/10/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 07 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments The Mini Gym #2 is the multi-purpose building constructed in November 2002 as an unattached Type V(III) building. The structure is used for sports activities and is principally equipped with a basketball floor and hoops. There is a fire alarm system installed in the building and exiting classification is remote capability. Battery pack emergency lighting is provided. The Mini Gym #2 building was vacated in June 2011 and is no longer utilized by facility clients. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000	refer to CMS 2567 RECEIVED APR 17 2012 FACILITY STANDARDS	

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
S Bruce	ADMINISTRATIVE DIRECTOR	4/10/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 08 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

The structure was built in January 1945 and serves as an auto repair shop.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, and in accordance with 42 CFR 483.70.

The Survey was conducted by:

Taylor Barkley
Health Facility Surveyor
Facility Fire Safety and Construction

K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

This Standard is not met as evidenced by:

Based on observation and interview it was determined that the facility did not ensure that the portable fire extinguishers were being inspected on a monthly basis in accordance with NFPA 10. Inspecting the fire extinguishers on a monthly basis helps to ensure the extinguishers are in their proper location and are ready for use in the event they are needed. The facility had a census

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
ABroetje	ADMINISTRATIVE DIRECTOR	4/10/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

'ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 08 B. WING _____	03/20/2012

ÀME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 1 of forty seven clients on the day of survey. This deficiency affected all clients, staff and visitors present on the day of the survey. Findings include: During a tour of the facility on March 20, 2012 at 10:15 AM, observation of the inspection tags affixed to the portable fire extinguishers revealed that they had not been dated or signed since November of 2011. When questioned about the fire extinguisher inspections a shop staff member stated that he was unsure why the test was not completed and documented. Actual NFPA Standard: NFPA 10 Standard for Portable Fire Extinguishers 1998 Edition 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.	K 130	**Tag # K130 (MM309) – Auto Repair Shop - page 2 of 2** During the tour of the facility on March 20, 2012 at 10:15, observation of the inspection tags affixed to the portable fire extinguishers reveal that they had not been dated or signed since November of 2011. When questioned about the fire extinguisher inspections a shop staff member stated that he was unsure why the test was not completed and documented. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required inspections. Fire extinguisher inspections will be completed by the 20th of each month and documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* B. Discipline responsible for monitoring system changes for Maintenance of Compliance. *Maintenance and Operations Supervisor* C. Date of action for the identified problem. *Will be completed by April 30, 2012*	4/30/12

ureau of Facility Standards

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 08 B. WING _____	03/20/2012

IAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments The structure was built in January 1945 and serves as an auto repair shop. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000	RECEIVED APR 17 2012 FACILITY STANDARDS refer to CMS 2567	
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities. This Rule is not met as evidenced by:	MM309		

ureau of Facility Standards

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 08 B. WING _____	03/20/2012

IAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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MM309	Continued From Page 1 Refer to the Federal K Tags on the CMS 2567; 1. K130 Fire extinguisher inspections.	MM309	refer 2567	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 09 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

The structure was built in January 1954 and serves as an auto detail shop.

The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and 42 CFR 483.70.

The Survey was conducted by:

Taylor Barkley
Health Facility Surveyor
Facility Fire Safety and Construction

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
S Bruce	Administrative Director	4/10/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ureau of Facility Standards

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 09 B. WING _____	03/20/2012

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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M 000	16.03.11 Initial Comments The structure was built in January 1954 and serves as an auto detail shop. The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) The Survey was conducted by: Taylor Barley Health Facility Surveyor Facility Fire Safety and Construction	M 000	RECEIVED APR 17 2012 FACILITY STANDARDS refer to CMS 2567	

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje | ADMINISTRATOR DIRECTOR | 4/10/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 10 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 000	INITIAL COMMENTS The structure was built in January 1944 and serves as the central laundry. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, and in accordance with 42 CFR 483.70. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by:	K 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
SBrodt	ADMINISTRATIVE DIRECTOR	4/10/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 10 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 130	Continued From page 1 Based on interview and record review it was determined that the facility failed to ensure that the manual fire alarm system was being maintained in accordance with NFPA 72. Failure to conduct annual inspections and testing could result in the fire alarm system not functioning as designed. The facility had a census of five clients on the day of survey. These deficiencies affected all clients, staff, and visitors present on the day of the survey. Findings include: During record review on March 20, 2012 at 9:45 AM, it was revealed that the last documented annual fire alarm inspection report was dated January 3, 2011. When questioned about the annual inspection the Maintenance Supervisor stated that he was aware that the inspection was overdue. Actual NFPA Standard: NFPA 72, National Fire Alarm Code. 7-3 Inspection and Testing Frequency. 7-3.1* Visual Inspection. Visual inspection shall be performed in accordance with the schedules in Section 7-3 or more often if required by the authority having jurisdiction. The visual inspection shall be made to ensure that there are no changes that affect equipment performance. 7-3.2* Testing. Testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. If automatic testing is performed at least weekly by a remotely monitored fire alarm control unit	K 130	**TAG #K130 (MM309) – Laundry - page 2 of 3** During record review on March 20, 2012 at 9:45 AM, it was reveled that the last documented annual fire alarm inspection report was dated January 3, 2011. When questioned about the annual inspection, the Maintenance Supervisor stated that he was aware that the inspection was overdue. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. Annual fire alarm inspections will be scheduled by the 1st of the month due. Documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* *The 2012 fire alarm inspection was initiated on 3/20/12 and we received the report of findings on 4/6/12.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. Maintenance and Operations Supervisor C. Date of action for the identified problem. *New system will be in place by May 30, 2012*	5/30/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 10 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 130	Continued From page 2 specifically listed for the application, the manual testing frequency shall be permitted to be extended to annual. Table 7-3.2 shall apply.	K 130		

ureau of Facility Standards

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 10 B. WING _____	03/20/2012

IAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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M 000	16.03.11 Initial Comments The structure was built in January 1944 and serves as the central laundry. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000	RECEIVED APR 17 2012 FACILITY STANDARDS refer cms 2567	
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities. This Rule is not met as evidenced by:	MM309		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM309	Continued From Page 1 Refer to the Federal K Tags on the CMS 2567; 1. K130 Fire alarm system maintenance.	MM309	refer to CMS 2567	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 11 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The Therapy Pool building was built in January 1984 and is Type V(III) construction. The facility currently uses the unattached building as a therapy pool which makes up 70% of the interior floor space inside. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, and in accordance with 42 CFR 483.70. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by:	K 130		

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APR 17 2012
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATIVE DIRECTOR	4/10/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

)EPARTMENT OF HEALTH AND HUMAN SERVICES
:ENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 11 B. WING _____	03/20/2012

IAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 1 Based on record review and interview it was determined that the facility did not ensure that the emergency lights were being tested for 30 seconds a month. Failure to test the emergency lights can result in nonoperational units not being discovered and repaired. The facility had a census of forty seven clients on the day of survey. This deficiency affected all clients, staff and visitors present on the day of the survey. Findings include: During record review on March 20, 2012 at 10:04 AM, it was revealed that emergency light testing records were not available for the month of May 2011. When questioned about emergency light testing records the Maintenance Supervisor stated that he was unsure why the test was not completed and documented. Actual NFPA Standard: 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 130	**TAG #K130 (MM309) – Therapy Pool Building - page 2 of 2** During the review on March 20, 2012 at 10:04 AM, it was revealed that emergency light testing records were not available for the month of May 2011. When questioned about emergency light testing records the Maintenance Supervisor stated that he was unsure why the test was not complete and documented. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. Emergency light testing will be completed by the 20th of each month and documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor* C. Date of action for the identified problem. *New system will be in place by May 30, 2012.* 5/30/12	

ureau of Facility Standards

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 11 B. WING _____	03/20/2012

IAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments The Therapy Pool building was built in January 1984 and is Type V(III) construction. The facility currently uses the unattached building as a therapy pool which makes up 70% of the interior floor space inside. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000	RECEIVED APR 17 2012 FACILITY STANDARDS refer to CMS 2567	
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities.	MM309		

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DBroetje | ADMINISTRATIVE DIRECTOR | 4/10/12

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 11 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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MM309	Continued From Page 1 This Rule is not met as evidenced by: Refer to the Federal K Tags on the CMS 2567; 1. K130 Emergency light testing.	MM309	refer to cms 2567	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 12 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Ramsey is an unattached single story building and is Type V(III) construction. The building is used as an educational unit/school on campus. There is a fire alarm system installed throughout the building with horn strobe units in classrooms and is off site monitored. Local school district contractors provide services within the building. The building was constructed in 1951 and has a partial basement. Exiting classification is remote capability. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, and in accordance with 42 CFR 483.70. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000	RECEIVED APR 17 2012 FACILITY STANDARDS	
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DBroetje ADMINISTRATIVE DIRECTOR 4/10/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 12 B. WING _____	03/20/2012

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 1 This Standard is not met as evidenced by: 1. Based on record review and interview it was determined that the facility did not ensure that the emergency lights were being tested for 30 seconds a month. Failure to test the emergency lights can result in nonoperational units not being discovered and repaired. The facility had a census of forty seven clients on the day of survey. This deficiency affected all clients, staff and visitors present on the day of the survey. Findings include: During record review on March 20, 2012 at 9:55 AM, it was revealed that emergency light testing records were not available for the month of May 2011. When questioned about emergency light testing records the Maintenance Supervisor stated that he was unsure why the test was not completed and documented. 2. Based on interview and record review it was determined that the facility failed to ensure that fire alarm was being maintained in accordance with NFPA 72. Failure to conduct annual inspections and repairing nonoperational equipment could result in the fire alarm system not functioning as designed. The facility had a census of five clients on the day of survey. These deficiencies affected all clients, staff, and visitors present on the day of the survey.	K 130	**TAG #K130 (MM309) (#1) – Ramsay - Page 2 of 3** During record review on March 20, 2012 at 9:55 AM, it was revealed that emergency light testing records were not available for the month of May 2011. When questioned about the emergency light testing records the Maintenance Supervisor stated that he was unsure why the test was not completed and documented. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. Emergency light testing will be completed by the 20th of each month and documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. *Maintenance and Operations Supervisor* C. Date of action for the identified problem. *New system will be in place by May 30, 2012.* 5/30/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 12 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 2 Findings include: During record review on March 20, 2012 at 9:50 AM, it was revealed that the last documented annual fire alarm inspection report was dated January 3, 2011. When questioned about the annual inspection the Maintenance Supervisor stated that he was aware that the inspection was overdue.	K 130	**TAG #K130 (MM309) (#2) – Ramsay - Page 3 of 3** During record review on March 20, 2012 at 9:50 AM, it was reveled that the last documented annual fire alarm inspection report was dated January 3, 2011. When questioned about the annual inspection the Maintenance Supervisor stated that he was aware that the inspection was overdue. A. Correction action for the identified problem. *A schedule and documentation of completion checklist will be developed for all required testing. Annual fire alarm inspections will be scheduled by the 1st of the month due. Documentation of the testing will be submitted to the Maintenance and Operations Supervisor who will review the documentation to ensure completion by the end of the month.* *The 2012 fire alarm inspection was initiated on 3/20/12 and we received the report of findings on 4/6/12.* B. Discipline responsible for the monitoring system changes for the Maintenance compliance. Maintenance and Operations Supervisor C. Date of action for the identified problem. *New system will be in place by May 30, 2012*	5/30/12

ureau of Facility Standards

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 12 B. WING _____	03/20/2012

IAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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M 000	16.03.11 Initial Comments Ramsey is an unattached single story building and is Type V(III) construction. The building is used as an educational unit/school on campus. There is a fire alarm system installed throughout the building with horn strobe units in classrooms and is off site monitored. Local school district contractors provide services within the building. The building was constructed in 1951 and has a partial basement. Exiting classification is remote capability. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000	RECEIVED APR 17 2012 FACILITY STANDARDS refer to CMS 2567	

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: SBuetze — TITLE: ADMINISTRATIVE DIRECTOR — (X6) DATE: 4/10/12

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 12 B. WING	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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MM309	Continued From Page 1	MM309		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities. This Rule is not met as evidenced by: Refer to the Federal K Tags on the CMS 2567; 1. K130 Emergency light testing. 2. K130 Fire alarm inspection.	MM309	refer to CMS 2567	

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 13 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO TREATMENT CENTER	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 000	INITIAL COMMENTS	K 000		

The Chapel is an unattached building that is Type V(III) construction built in January 1974. The building has a smoke detection system installed. Exiting classification is remote capability.

The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and 42 CFR 483.70.

The Survey was conducted by:

Taylor Barkley
Health Facility Surveyor
Facility Fire Safety and Construction

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATIVE DIRECTOR	4/16/12

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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 13 B. WING _____	03/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 000	16.03.11 Initial Comments The Chapel is an unattached building that is Type V(III) construction built in January 1974. The building has a smoke detection system installed. Exiting classification is remote capability. The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted between March 19, 2012 and March 20, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000	refer to cms 2567 RECEIVED APR 17 2012 FACILITY STANDARDS	

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ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

J Bud — ADMINISTRATIVE DIRECTOR — 4/10/12

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